PROVIDER CHANGE OF INFORMATION FORM

Provider Name: _____

Provider Number (s) affected by the change: _____

Old Service Address:	**New or Additional Service Address:**	
		Phone:
Old Pay - To Address:	**New Pay – To Address:**	
		Phone:
Old Mail - To Address:	**New Mail - To Address:**	
		Phone:
Old Billing Service Address:	**New Billing Service Address:**	
		Phone:

☐**Change in Ownership Interest or Corporate Status: (Requires New W-9)**

- New Owner's Name(s):_____
- Address: _____
- Date of Change of Ownership Interest: _____
- Process by which change occurred: (i.e. merger, sale, gift, etc.) _____
- New Corporate Status: _____

☐**Change to Certification:**

- Previous Certification: _____
- Current Certification: _____
- Date of Change: _____

☐**Notification of Adverse Action to License:**

- Action taken: _____
- By what Agency: _____
- Date action effective: _____

☐**Notification of Bankruptcy Filing:**

- Date of filing: _____
- Type: _____
- Attorney Name and Address: _____
  _____
- Trustee Name and Address: _____
  _____

Authorized Signature: _____**Date** _____

(Signature required to make change)

Print Name and Title: _____

- Please attach a separate piece of paper if necessary. Thank you for your cooperation.
- Please either FAX Change of Information Form to **(401) 784-3892** or mail to the following address within 35 days of the event triggering the reporting obligation:

HP Enterprise Services – Provider Enrollment Unit

PO Box 2010
Warwick, RI 02887-2010